

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED APR 12 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

10186  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan

Registration District No. 35

(b) Township St. Joseph Mo.

Primary Registration District No. 1001

(c) City St. Joseph Mo.

(d) Street No. State Hospital No. 2.

Registered No. 259

(e) Length of residence in city or town where death occurred 1 yr.

(f) How long in U. S., if of foreign birth? 1 yr.

2. PRINT FULL NAME

(a) Residence, No. 5142 Michigan St. C. Mo. St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 26<sup>th</sup> 1894

7. AGE

YEARS 43

MONTHS 6

DAYS 8

If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis U. S. Missouri.

FATHER

13. NAME Edward Nelson.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Sweden.

MOTHER

15. MAIDEN NAME Louise Larson.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Sweden.

17. INFORMANT (ADDRESS) State Hospital # 2 St. Joseph Mo.

18. BURIAL, CREMATION, OR REMOVAL St. Joseph.

PLACE Mt Auburn

DATE March 5<sup>th</sup> 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. O. Sideraden & Son 1802 Union Ave. St. Joseph Mo.

20. FILED Mar. 5, 1940

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 4<sup>th</sup> 1940

22. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1939 to March 4, 1940

I last saw her alive on March 4, 1940 Death is said

to have occurred on the date stated above, at 12:30 m.

The principal cause of death and related causes of importance were as follows:

Rheumatic Heart Disease  
Mitral Stenosis

Date of onset 3-6-40

Other contributory causes of importance:

Obesity

Name of operation None Date of None

What test confirmed diagnosis? Chol Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? NO Date of injury None, 19...

Where did injury occur? None (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify 36 Miles

(Signed) J. E. Miles, M. D.

(Address) State Hospital

St. Joseph Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*not Embalmed*  
*Charles W. Rockwell*

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**